No. 2
1-4-41
17-39
X26390

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 6 1941

Registration District No. 2166

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5505

State File No. 35095

Registrar's No. 4

1. PLACE OF DEATH:
(a) County Nicholas
(b) City or town Hermitage Centre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1
In this community 30 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Nicholas 043
(c) City or town Hermitage
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Lavona West
3. (b) If veteran, name war
3. (c) Social Security No. none

4. Sex F. | 5. Color or race W. | 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife George Thomas West | 6. (c) Age of husband or wife if alive —

7. Birth date of deceased Jan 24 1869 (Month) (Day) (Year)

8. AGE: Years 72 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Camden Co. Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Wm B. Jones.
13. Birthplace Kentucky (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Jane Wilson
15. Birthplace Lake Jean (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Sarah Wilson
(b) Address Hermitage Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21-41 (Month) (Day) (Year)

(c) Place: burial or cremation Hermitage

18. (a) Signature of funeral director [illegible]
(b) Address Wheatland Mo

19. (a) Oct 6 1941 (Date received local registrar) (b) Anna McLendon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19
year 1941 hour 6 minute 35 A.M.

21. I hereby certify that I attended the deceased from July 2, 19 41, to Sept 19 19 41
that I last saw h[illegible] alive on Sept 19 19 41
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac and circulatory failure	
Due to Pneumonia	4 Days
Due to Complicated with interstitial Nephritis	
Other conditions (Include pregnancy within 3 months of death) Bronchial asthma	4 Days

Major findings:
Of operations 330
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature C. D. Bailey (M. D. or other) Mo.
Address Hermitage Mo. Date signed Sept 30

37 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 11-41-1793
Date Filed 11-4-41

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. P. Lucky

Licensed Embalmer No. 2982.

P. O. Address Whitehall M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.